Pflugers Archiv., Bd. xv., iv. and v. Hft.; **LANGENDORFF**, On Reflex Inhibition, *Archiv. f. Anat. u. Phys*, Phys. Abth., i. and ii., 1877; **KLUG**, Physiology of the Space-Sense of the Upper Extremity, *Ibid*, ii.; **HERMANN**, Researches on the Development of the Muscle-Current, *Pfluegers Archiv*., xv., iv. and v.; **BERNSTEIN**, On Fatigue and Recovery of Nerves, *Ibid*, xv., vi. and vii.

b.—PATHOLOGY OF THE NERVOUS SYSTEM AND MIND, AND PATHOLOGICAL ANATOMY.

NERVOUS SYMPTOMS WITH EAR DISEASE.—Dr. Hughlings Jackson, *Lancet*, (Am. Rep'r.) June, considers the following nervous affections occurring in connection with ear disease; neuralgic pain, Bell's paralysis, tumor of brain, abscess and meningitis, hemiplegia, epilepsy and epileptiform seizures, and aural vertigo. Some of these, as he says, can only be considered as associated with aural trouble, their relations are not otherwise clear.

Neuralgic pain, he thought, was probably only symptomatic of exacerbation of the tympanic disease, and, *as a rule*, did not precede meningitis or abscess, but sometimes preceding paralysis of the face, it may lead to a false diagnosis of "rheumatic" paralysis of the portio dura nerve.

The following remarks were made on unilateral facial paralysis: (*a*) He had never met with paralysis of the palate in uncomplicated facial palsy. An obliquity of the uvula indicated nothing, since it might occur in healthy individuals. If paralysis of the palate was met with he should suspect not a dependence upon ear disease, but intracranial trouble. There would be two lesions, and if the symptoms came on slowly he should suspect syphilis. (*b*) Uncomplicated facial paralysis with ear disease is not an intracranial or cerebral, and hardly an aural symptom; it is a bone symptom. (*c*) It is occasionally the precursor of serious intracranial trouble, but not often, and their relations are only those of coincidence. (*d*) It is erroneous to infer that because the causal lesion of the palsy is a gross one, that recovery will necessarily not occur. (*e*) The facial palsy does not even indicate serious extension of the ear disease, but only extension in an unfortunate direction. The occurrence of intense pain in the head would be a much more serious symptom.

In some cases of chronic ear disease he had found a mass of tubercle in the cerebrum or cerebellum in the place, so to speak of an abscess from aural disease. Except, perhaps, in chronicity, there are no distinguishing symptoms between the two.

Meningitis and abscess were mentioned together on account of the difficulty in diagnosing one from the other. Abscess was much the most frequent, however, and therefore the safer to predict. Perhaps the very early appearance of optic neuritis, if well marked, would point to abscess. An abscess, as is well known, may give rise to no symptoms, and when then they do come on the case is usually acute, and may simulate meningitis. Some cases of tumor have very similar symptoms, the presence of ear disease is then useful, but not conclusive, since tubercle may occur from aural trouble. Moreover, the symptoms of brain abscess are, generally, only severe headache and vomiting, which may lead to the mistake of diagnosing stomach or liver derangement. The intensity of the headache, its frequent unusual locality, and the purposelessness of the vomiting, (often with clean tongue) should negative this diagnosis. If the opthalmoscope were used in all cases of severe headache, some diagnostic mistakes might be avoided. There is often optic neuritis, but as this is often unattended with impaired vision, it is not often looked for. Delirium is not a good evidence of acute brain affections from ear disease. A patient may recover for a time from cerebral abscess, and it is clinically worth remembering that a patient with abscess from ear disease may, without being apparently near death, die very suddenly.

Hemiplegia occurs sometimes in children with ear disease, and though the post mortem evidence is wanting, the possibility of venous thrombosis leading to local softening is suggestive.

In the cases in which epilepsy or epileptiform attacks occur with aural trouble, the author does not accept the explanation that the attacks are due to reflex irritation, but suggested that the aural disease has led to trouble in Hitzig's or Ferrier's regions. He thought it possible that the disease is sometimes softening from venous thrombosis, the convulsions depending upon an instability of gray matter around the softened regions, and believed he had some indirect evidence of this.

As regards aural vertigo, or Menière's disease, the author thought that any kind of ear disease would cause vertigo, and reeling with faintness and vomiting, and it was his opinion that the paroxysm always depends on trouble in the auditory expansion in the labyrinth, whether from actual lesion therein or trouble from without. There are also chronic cases as well as paroxysmal ones, thus there are cases of ear disease in which giddiness appears whenever the patient walks. The paroxysms are usually explained by the laity, and sometimes by medical men, as being due to stomach or liver trouble. The author urged that the mere concurrence with deafness with the paroxysmal or chronic symptoms should not alone settle the diagnosis. He passed in review the most characteristic symptoms of five great varieties of vertigo: (1), stomachic; (2), nervous (often sexual) exhaustion; (3), ocular; (4), epileptic; (5), aural or auditory. Great attention should be paid for diagnosis, to what Knapp has called the limitations of the "field of audition," to the loss of perception of certain notes; if the loss were of some *intermediate* notes it would, the author thinks, point to disease in the cochlea. He tried to show how we should distinguish betwixt a case of chronic unsteadiness from aural disease, that from cerebellar disease, and that from ocular palsy. Finally, he gave his speculations as to the *modus operandi* of the ear disease. There were two sets of symptoms: *a*, "vital," (faintness, perspiration, irregularity of pulse, etc.); *b*, locomotor (vertigo, with or without reeling). He attributed the former to disturbance of, or actual disease in, the cochlear division; the latter to disease or disturbance of the semi-circular canal divisions; the former division was, he suggested, chiefly afferent to the medulla oblongata, the auditory nucleus having (Lockhart Clarke) close connection with the vagal and spinal accessory nuclei; the latter division, he thought, represented the part going, according to Lockhart Clarke, to the cerebellum. The "vital" and locomotor symptoms were due to disturbance of the medulla and cerebellum respectively. He referred to Goltz's theories; to the experiments by Vulpian and others, on the semicircular canals. He mentioned that Pierret had recently spoken doubtfully as to the existence of relations betwixt the auditory nerve and the cerebellum. Cyon has recently found that irritation of each of the semicircular canals is followed by a particular ocular movement; a very significant thing towards the interpretation of auditory vertigo.

CHOREA.—A paper read before the British Medical Association Aug. 9 by Dr. Gowers, is thus reported in the *Brit. Med. Journal*, Aug. 25. The object of the paper was to illustrate by cases some points in the common or occasional clinical history of chorea which have hitherto received little attention. 1. *An increase in the irritability to electric stimulation*, to both faradic nad voltaic stimulation. The change can be observed best in cases of hemichorea. Five cases were narrated in which it was observed, and in some of these it was proved to disappear on the subsidence of the chorea. The same fact has been noted by Benedikt and Rosenthal, who have also observed a change in the nerve reaction to voltaism, which Dr. Gowers partially confirms. The significance of the increased irritability is probably an altered state of nutrition of the fibres of the nerves and of the motor nerve-cells of the spinal cord, under an irritation transmitted downwards from the diseased cerebral region, and is another illustration of altered nutrition in functional disturbance. 2. *The relation of the muscular disturbance of chorea to voluntary movement.* The inco-ordination of voluntary movement varies independently of the spontaneous spasmodic movements. Instances were mentioned in which the spontaneous movements were slight and the inco-ordination great, in which there was much spontaneous movement and little or no inco-ordination, and in which the relative proportion of the two varied at different periods of the same attack. Reasons were given for regarding the inco-ordination as something distinct from mere inability of the will to still the spontaneous spasm. As far as the observations went, they suggested the conclusion that the spontaneous spasm was in excess late in a case and during relapses. The independent variation of the two elements suggests that they depend on a morbid condition of distinct and perhaps separate regions. 3. *The relation of chorea to other convulsive affections.* If chorea depends on an unstable condition of gray matter, it is not surprising to find it occasionally associated with other diseases which we ascribe to a similar instability, such as hystero epileptic and epileptoid convulsions of various kinds, and even true epilepsy. In illustration of this, a series of cases were narrated exhibiting, 1. Chorea, with remarkable choreo-epileptic seizures during the height of the affection; 2. General chorea succeeding unilateral convulsions of six months duration; 3. Chorea, succeeded immediately by persistent unilateral convulsions, and hystero-epileptic fits; 4. Chorea, more severe on one side, succeeded immediately by convulsions on that side; 5. Chorea, followed after an interval of some years by epileptoid; 6. Chorea, succeeded after many years by true epilepsy.

THE MOVEMENTS OF THE EYES IN COMA.—Mr. Chas. Mercier, assistant demonstrator of anatomy at the London Hospital, calls attention to the independent movements of the eyes in coma, as follows, in the ***British Medical Journal***, Mar. 10.

In every case of loss of consciousness, in which the coma has reached a certain depth, or, in other words, at a certain stage in the onset of coma, the eyes lose their normal correspondence and move independently of each other. Usually the optic axes diverge; but divergence is by no means essential, and when it exists is only temporary. One eye may be at rest while the other is in motion, or both may be moving in different directions and at different rates; the positions assumed being often most striking and unnatural, but quite inconstant and uncertain. The movements are never "spasmodic," that is, abrupt, but always slow rolling, gliding motions. They have no relation whatever to the cause of the loss of consciousness, but only to its degree. I have seen them in coma from injury to the head, from cerebral hemorrhage, from alcoholism, from uraemia, from "simple apoplexy" after an epileptic fit, and in profound anæsthesia from chloroform and ether. I have never failed to find them in any case of deep coma that I have examined.

The degree of coma with which this appearance corresponds is most readily observed in the artificial production of loss of consciousness by anæsthetics. After the first purely voluntary struggling, comes usually a period of quiescence and delirium, and then a second struggle from which the patient gradually passes into "surgical anæsthesia," in which the conjunctiva is insensitive. It is usually just at this point, at the end of the second struggle, and just before the conjunctiva ceases to be sensitive, that the independent movements of the eyes begin, and the return of the optic axes to parallelism is a certain indication that anæsthesia is passing away.

So invariable is this sign, that I have been in the habit, when administering chloroform and ether, of taking these movements as the indication of the degree of anæsthesia, instead of the rather barbarous method of rubbing off the corneal epithelium with the finger.

The independent movements have also, I believe, a great diagnostic value. Since it is clearly quite impossible for any one to simulate them by an effort of will, their existence forms a ready and certain means of excluding malingering and hysteria from the diagnosis of a case. The movements are in no degree an active process; but are simply dependent on loss of control, and what Dr. Hughling Jackson calls "reduction in automaticity." In this connection, it is interesting to note that, in some of the lower animals (*e. g.* the chameleon), the eyes normally move independently.

The terms coma and loss of consciousness are used here in a wide sense, to include not only the state of profound stupor, with stertorous breathing, etc., but also, all the stages which precede this graver degree.

Immediately following the above is another short communication from Dr. Francis Warner, medical registrar to the same hospital, on the same subject as follows:

The movements of the eyes have been studied with much care, and present a field for clinical observation. I wish now to direct attention to the loss of association in the movements of the eyes in patients deeply under the influence of chloroform, and in some cases of disease, and congenital defects of the brain. In the healthy subject, the eyes when moving in the horizontal plane are strictly parallel; when they are directed upward they diverge slightly but symmetrically; similarly when they are directed downward they converge symmetrically. In looking at near objects they also converge. Now in each of these physiological departures from paralellism, the inclination of the axis of the eye towards or from the median plane, is equal on the two sides, and those associated movements are supposed to be due to certain "brain centres," which govern such associated movements.

1. Preserving parallelism when they move horizontally.
2. Governing convergence when accommodating for near vision.
3. Governing divergence or convergence as the individual looks at an object above or below the horizontal plane.

When a patient is being placed under chloroform, the eyes first roll upwards as in sleep, and, in so doing, they diverge symmetrically, as when they roll up from any other cause. When the patient is fully comatose, and before he begins to breathe stertorously, there is *a loss of association* in the movements of the two eyes. At this stage of temporary brain paralysis, the eyes are usually directed in the horizontal plane (or what would be the horizontal plane were the patient in the vertical position). In this condition, *one eye may remain perfectly quiescent, while the other slowly wanders* either inwards or outwards; the same thing may then recur, or the other eye may remain at rest, or the two eyes may both move, but without any association of movements except that they both, (generally at least) keep at the same level. I have myself never seen the same phenomena in the coma produced by ether; presumably because with ether surgical coma may be brought about by a less degree of brain paralysis than in the use of chloroform. This is an argument in favor of the greater safety of ether as an anæsthetic.

The following case came under my care at the Children's Hospital, Birmingham. A girl, three years of age, was the snbject of permanent paralysis of one arm and leg following convulsions in infancy. She had never been able to speak, was constantly dribbling and idiotic in manner. On observation there was seen to be an occasional loss of parallelism of the eyes: one would remain at rest, while the other wandered inwards or outwards; this was a chronic condition in the child, who was suffering from no acute disease.

I have seen a few similar instances, one in conjunction with two other physicians, who confirmed my observations. In a few instances, I have seen the same thing in acute cerebral meningitis. In considering the physiological significance of this condition. I think the cases quoted indicate that it is due to paralysis of certain portions of the brain, and that it is not due to any spasmodic action of the recti muscles. If it be granted that a brain centre governs the horizontal parallel movements of the eyes, this centre must be paralyzed in the condition referred to. Chloroform administered to the stage of complete surgical anæsthesia, and just short of producing stertorous breathing, paralyzes this centre; ether may produce surgical anæsthesia without paralyzing it. These observations are incomplete, and the deductions crude; but I have thought the subject worthy of notice, and of clinical interest.

NERVOUS AFFECTIONS OF THE SKIN—Hebra u. Kaposi, Lehrb. d. Haut krankh., 2 B., 3 Lief. Nervenkrankheiten der Haut. *Deutsche Med. Wochensch.*, No. 9. According to the authors definition only those pathological conditions of the skin are to be considered as neuroses, "which appear as the expression of their abnormal or disordered innervation, without the possibility of finding in the tissues of the skin itself, together with its nerves, and with the present methods of investigation, any demonstrable pathological alteration." We have, therefore, to exclude a series of processes, that certainly very often stand in connection with certain nervous conditions, but which apparently manifest themselves in definite alterations of the cutaneous tissues, such, for example, as herpes zoster, various pigmentations, psoriasis, etc., and also the central or peripheral nerve lesions connected with anæsthesia and algesia. The authors also exclude the vaso-motor disturbances, the angio- or trophoneuroses of Eulenberg and Landois, from the cutaneous neuroses, since the vaso-motor nerves are more or less implicated in all skin affections, and it is very far from certain whether they are the primary disorders.

There remain, therefore, since the single motility neurosis, the cutis anserina, is to be considered as a physiological phenomenon, only very few skin affections affecting the sphere of sensibility, to be considered. Together with hyperæsthesia and hyperalgesia, anæsthesia and analgesia, which almost exclusively depend on a hysterical condition, we have, as a genuine neurosis of interest to the dermatologist occurring without external irritation, a condition of skin alteration known as pruritus.

"Pruritus is a chronic skin disease which makes itself known alone for months and years by a sensation of itching, while it reveals in the skin no efflorescence or other alteration except such as result from the scratching caused by the itching," and it is distinguished from prurigo, which, according to most authors is not considered as a nervous disorder but rather an exudation process, in which the itching depends upon a nodular eruption and ceases when the eruption goes away.

As etiological moments of pruritus universalis are given, senile marasmus, chronic gastric disorder, the climateric period, menstrual troubles, Bright's disease, diabetes mellitus, tuberculosis, carcinoma of the intestines, icterus, and finally, depressing psychic affections; the prognosis is hence not absolutely unfavorable in all cases. Pruritus senilis is incurable.

Pruritus localis affects almost exclusively the genitals and the anus;

it is rarely met with in the palm of the hand, the sole of the foot, the tongue, and the urethra. Disorders of the sexual organs, uterine cancer, helminthiasis, and hemorrhoid are the usual causes.

The itching of the skin coming on in winter time (pruritus hyemalis) is, according to the author, due to the chilling of the cutis by the cold dry atmosphere, and is therefore, as the result of an external irritation not to be reckoned as a neurosis.

It is evident that the first therapeutic aim must be to attack the cause of the disease, but in all cases the patients first desire the removal of the unendurable itching. Tar is absolutely worthless, on the other hand such agents are to be recommended as will rapidly produce a local cutaneous anæsthesia. Cold douches, washing with acidulated water, alcohol, æther, carbolic acid with subsequent powdering the surface to delay the evaporation of these fluids. The author recommends the following formula:

℞		
Acid Carbol., - - - - - -	1.5	grammes
Sp. Vini Gallici, - - - -	300	"
Glycerine, - - - - - - -	5	"
or		
Ætheris Petrolei, - - - - - -	4	grammes
Spirit., - - - - - - - -	180	"
Glycerine, - - - - - - - -	4	"

Sometimes warm baths, with or without soda or sublimate are of advantage. In pruritus of the genitals, astringents and likewise applications are of benefit. Of internal medicines, arsenic has not proved useful, but on the contrary carbolic acid (0.1 per dose 0.6 or 0.8 per diem) has been of use in some cases.

NEURALGIC HERPES OF THE GENITALS.—During the past year, we have given in the Periscope the title of a series of lectures delivered and published in Paris by M. Mauriac, which have since been brought in a separate *brochure*. We extract the following notice of this work from *La France Médicale*.

This memoir of some 112 pages is the reproduction of the clinical lectures delivered by the author at the Hospital de Midi. M. Mauriac, if he makes no pretenses to its discovery, yet wishes to call attention to a pathological subject, still little studied in spite of its frequency. Neuralgic herpes has been almost neglected up to the present time, and that it has been observed only in males, though he does not nevertheless deny its existence in the female. Neuralgic herpes produces perversions of sensibility, hyperæsthesia, analgesia, anæsthesia, etc. The nervous perturbations precede, accompany or follow the appearance of herpes on the genitals, which, moreover, presents in a physiologico-pathological point of view many relations with zona.

The etiological moments of neuralgic herpes of the genitals are most frequently constitutional, they are first to be found in arthritism, herpetism follows next. There may be also, but remotely connected, scrofula, syphilis, diabetes, and nervosism.

After giving the pathogenetic theory of herpes zoster, M. Mauriac comes to the following conclusions, that it is most probable that neuralgic herpes of the genital organs is connected with a hyperæmic process that invades a greater or lesser extent of the sacral plexus. This irritation may depend upon a general state, a constitutional disposition, on which it is impossible to pronounce with certainty.

After general considerations on the symptoms, the processes, the diagnosis, the duration and the sequelæ of the disorder, M. Mauriac comes to the treatment, which consists in very slight cauterizations, followed by soothing ointments, containing calomel, baths, refreshing tisanes; mineral waters are indispensable, and the most serviceable are the chlorinated sodic and sulphurated waters, such as those of Uriage, etc.

THE ARTHROPATHIES IN LOCOMOTOR ATAXIA.—The following is the notice of a recent memoir on this subject by Dr. Joseph Michel, (Masson, Paris, 1877), in *La France Médicale.*, No. 39, May 16:

The study of these arthropathies is of recent date, it is even astonishing that this complication of ataxia, so remarkable by its progress, its symptoms and the lesions connected with it should have passed unobserved up to the year 1831, when it was noticed, incompletely it is true, by an American physician, J. K. Mitchell. In 1857, Alison took up the subject, but we have to come to Professors B. Ball and Charcot to find an accurate description of this complication, and the proofs of its relations to locomotor ataxy. M. Joseph Michel has collected twenty-three cases, scattered through medical literature or previously unpublished, and after having given an exact description of the appearance and forms of this arthropathy, he attempts to deduce from the study of pathological anatomy and physiology, the exact locality of the nerve lesion which is the primary cause of these articular troubles, and, without attaining any precise result, he shows, nevertheless, that the atrophy of the cells of anterior cornua is far from being constant, as was held by M. Charcot.

In fact, out of seven cases of which an autopsy was made, with histological examination of the cord, in two was atrophy of the anterior cornua found at the points from which arose the nerves going to the diseased joint; in two others there was a dubious and ill defined alteration of the gray substance, so indefinite indeed as to leave some doubt as to whether it really existed; and finally, in the three remaining cases, pathological anatomy was altogether silent and gave no information. "Therefore, in a certain number of cases," says M. Michel, "we observe the coincidence of the arthropathy and a lesion of the large gray cells of the cord, and, on the other hand, there exist cases not less numerous, in which is the arthropathy without our being able to prove the existence of the lesion of the cells." To-day the question is still in the same condition as in 1875, when M. Blum, in his *Thése d'agregation* wrote as follows: "To establish a connection of cause and effect between the ataxic arthropathy and the lesion of the cells of the anterior horns is an ingenious way of viewing the subject, but one, that in the actual state of the question, cannot be admitted except with the most extensive reservations." Two observations published since then (Raymond and Bonneret) having both furnished negative results as to the lesions of the anterior horns, allow us to be more affirmative in the doubt than was M. Blum.

We cannot analyze all the chapters of this memoir; we will mention, however, the part that relates to the differential diagnosis of the ataxic arthropathy from dry arthritis, also the chapter on the pathological anatomy. The following are the conclusions of the author, who has been able to give only an hypothesis of the origin of the lesion, which, being based upon physiology, seem to us to approach very near to the truth:

"The arthropathies occurring in the course of locomotor ataxia are actually under dependence to the nervous system. It is, perhaps, the vaso-motor paralysis that is the predisposing cause, while the direct cause is a slight traumatism. Again they may arise from nervous irritation and exaggeration of trophic action; or the nervous system may manifest its action in a reflex way."

THE CAUSES AND PRODROMAL SYMPTOMS OF PSYCHIC AFFECTIONS.—Hecker, *Volkmann, Samml. Klin. Vortraege*, No 108. (Abstract in *St. Petersburger Med. Wochenschr.*) The author addresses himself to physicians not specialists in mental diseas s, to introduce to them their first symptoms and their treatment. Altogether, heredity is proven in about one-fourth of all the cases, and it is to be first of all considered. The first of the eight forms described he designates shortly as hereditary insanity. The hereditary element is shown in asymmetry of the skull, ill-formed ears, defective development of the genitals or of the whole body. With these are observed convulsions or chorea in youth, later disagreeable variable temper, irritability, lack of self-control, over-conceit, and with these often striking ability in certain directions, and talent. Here the physician must look to the bringing up. In the further development we do not meet with simple delusions, partly excepting the ideas of persecution, but biased childish judgments, which, with the lack of will power, are readily translated into acts; these acts are generally in violation of morals, and the patients know how to use sophistry to excuse them, hence the narrower designations of this form of disease as moral insanity, *folie raissonante*, or mania sine delirio (typica, Kahlbaum). These cases on the whole, afford but little prospect of a perfect cure, their course is variable and gradual. With the hereditary element which is also present in other forms of insanity, the following causes form one group, tumors of the brain, hemorrhages, meningitis, syphilis, cardiac deficiency, uterine disease, stasis in the portal circulation, typhus, cholera, pneumonia, intermittent fever, and injuries of the head. The last named often develop their action years after their reception, by insidious inflammatory processes, or if cutaneous nerves are compressed by external scars, through the reflex irritation. All the above enumerated causes lead under certain circumstances to another well characterized form that is shown by headche, violent disposition and inability of the brain to withstand externalinfluences, those of spirituous drinks, for example. The mental power is weak, and the violence of the disposition manifests itself in outbreaks of temper and temporary insanity, which speedily pass over and give way to comparative good feeling. Epileptic attacks occur during the course of the disease. Of the outcome it is difficult to say anything special.

As a third form we have the well-known progressive general paralysis. In the beginning there are only slight fibrillary contractions and disturbance of speech, then emotional exaltation, perverted occupation, wasteful use of money, etc., then fits of madness and most extravagant ideas of personal importance, and finally complete dementia and general paresis and death after three or four years. As a fourth form of the disease we may mention the Katatony described by Kahlbaum. It likewise commences with convulsive phenomena like the preceding forms, in about half the cases, especially tonic in their character. It succeeds in a longer or shorter time a melancholic preliminary stage, distinguished by a sort of inflexibility of the entire disposition, and leads to melancholic attonita and flexibilitas cerea. Very frequently there is absolute taciturnity (*mutacismus*) or only the repetition of a few and the same phases, with this we notice the inclination to attach mysterious significations to the words and acts of others; finally there is added a still more pronouncedly negative affection, refusal of food, retention of urine, etc. This condition may pass either temporarily or permanently into an excited state with very decided hallucinations, and then either to cure or comparative health, or final dementia.

To the remarks on katatony, the author adds some general considerations upon melancholia. A melancholic stage, in its broader sense, occurs in the course of various psychoses, but by itself it affords us one phase of insanity which runs its course throughout only as a depressed condition of mind, connected also with pre-cardiac pain, and also with agitation, delusions and hallucinations (ideas of persecution and poisoning, etc.)

This form of disease passes into either recovery or some moderate degree of mental weakness. On account of the frequent attempts at suicide, isolation in an asylum is every way indicated, and rest, improvement of the nutrition, and of medicine, opiates, are the measures to be advised. The designation melancholia should not be retained, because, as said before, melancholic derangement is more frequently only a transition stage of various other psychoses or forms of disease. Kahlbaum has recommended that the genuine melancholia should receive the name dysthymia, in order that we might not give the same designation to different things. As a sixth form of mental disease, the author gives that one called hebephrenia, by Kahlbaum. Beginning almost always between the eighteenth and twenty-second year of life with a melancholic stage, the insane basis of which is recognized by the exaggerated complaints, and the simultaneous indifferent emotional condition and laughing countenance, there soon replaces the melancholia a silly excitability.

Seventhly, the author gives the description of mania. This is only a *Symptomcomplex*, a transition stage, and not a form of insanity by itself, and it exhibits like melancholia special characters in different varieties of the disease. In general the expression is characterized by exaltation, lively disposition and excitation of the conceptive activity to the point of complete loss of control and confusion of ideas. This stage of mania is present to a greater or less degree in all the above described varieties of insanity with the exception of the true melancholia (dysthymia of Kahlbaum). As a seventh species he recognizes that kind of mania periodically alternating with a melancholic stage (*folie circulaire*, cyclothymia of Kahlbaum) and which is lasting and incurable. In the exaltation stage the patients exhibit an apparent increase of activity; they lie, intrigue, and deceive, bluster and destroy with apparently perfect possession of their faculties and are therefore often not considered as at all insane. In women the nymphomaniac condition is common. Then, after awhile, the melancholic stage comes one, sometimes separated from that of mania by a period of apparent health, and so the non-medical observer considers the trouble, as a rule, to be only a very proper *Katzenjammer*. The treatment as a whole must be calmative and isolation in an asylum is essential. In conclusion the author describes an eighth variety of insanity. In this both the maniacal and melancholic phases are absent; the morbid process affects only the reasoning and understanding faculties and does not pass over into dementia. Fixed delusions are the characteristic. It is a genuine craziness (*Verrucktheit paranoia* of Kahlbaum). The delusions are constantly becoming more and more fixed and render the patient absolutely impracticable, while the mental faculties generally are only somewhat weakened.

THE ETIOLOGY OF HERPES LABIALIS AND OF ZONA.—The following are the conclusions of a recent memoir by Dr. Jorissene, of Liege, (*Ann. de la Soc. Méd. Chirurg. de Liege*, 1877,) as reported in the *Bull. Gén. de Thérapeutique*, July 30.

1. "Lactation is a predisposing cause of endocarditis and of herpes facialis, perhaps also of zona:

2. "*Herpes labialis* or *facialis* is a morbid process, pyretic or apyretic, sporadic or epidemic, transmissible (?) under certain circumstances (?) which develops itself exteriorly on the skin, and internally on the lungs, the pleura, occasionally on the stomach, the meninges, or the endocardium.

3. "Herpes zoster or zona is an entirely distinct affection from *herpes facialis*.

4. "Rheumatism is a predisposing cause of zona. Possibly we ought to include in our nosological classification, arthritic zona.

5. "In ophthalmic zona the neuritis precedes the cutaneous eruption, and may cause ocular troubles before the appearance of the exanthem.

6. "Zona is generally unilateral. Zona opthalmicus in the bilateral form has been observed only twice; in the case reported by Lailler when it was complete, and in the one reported by myself, in which it was arrested in its progress."

The following are the titles of some recent articles on the Pathology of the Nervous System and Mind, and on Pathological Anatomy.

BEARD, The Nature and Treatment of Neurasthenia (Nervous Exhaustion), Hysteria, Spinal Irritation and Allied Neuroses, *N. Y. Med. Record*, Sept. 15; RAGGI, On the Genesis of the Epileptiform or Apoplectiform Attacks in the Insane. *Rivista Clinica di Bologna*, July, 1877; KRAFFT-EBING, Insanity in the Climacteric Period, *Allg. Zeitschr. f. Psychiatrie*, XXXIV. iv. ; BJÖRNSTRÖM, Athetosis, *Upsala Lakareforenings Forhandlingar*, XII. vi.; DEECKE, The Structure of the Nervous Centres in Health, and their Changes in Disease, *Am. Jour. of Insanity*, July; KIERNAN, Katatonia, a Clinical Form of Insanity, *Ibid;* CATLETT, The Frequent Association of Diseases of the Ear with Insanity, *Ibid;* BILLOD, Contribution to the Study of Aphasia, *Ann. Med. Psychologiques*, May; TAGUET, Suicide in Hysteria, *Ibid.*

c.—THERAPEUTICS OF THE NERVOUS SYSTEM AND MIND.

SOPHORIA.—This is the name given by Dr. H. C. Wood, *Phil. Med. Times*, Aug. 4, to an organic extract or alkaloid obtained from the seeds of Sophora speciosa, a Texan plant sometimes used by the Indians of Southwestern Texas as an intoxicant.

The extract, as obtained, was of a yellowish white color, amorphous, soluble in acidulated water, and very freely in ether, but not in pure water. It was precipitated by alkalies.

The results of physiological experiments with an alcoholic extract of the bean, were as follows:

In *frogs* it produces a rapid loss of reflex activity and power of voluntary movement. The loss of power is not due to any action upon the motor nerve-trunks, as after death these were found to preserve their normal susceptibility. Further, tying the sciatic artery upon one or both sides of the frog did not influence the action of the drug upon either voluntary or reflex movements. This would indicate that the poison is a spinal sedative, and has little or no effect upon either motor or sensory nerves. In all cases the heart continued beating long after the cessation of respiration.

Upon mammals the effect varies somewhat in accordance with the dose. An amount of the extract estimated at two grains (?) produced in a full-grown tom-cat, in one minute, marked weakness in hind legs, in two minutes, inability to stand, with evident effect upon the respiration; in three minutes, convulsive movements, with loss of consciousness, continuing with ever increasing embarrassment of the breathing for three